MORRIS SUSSEX FAMILY PRACTICE

694 ROUTE 15 SOUTH * SUITE 103 * LAKE HOPATCONG, NJ 07849
973-663-8899

Financial Policy

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is DUE at the time of service. We currently accept cash, some credit cards and checks (subject to physician's discretion). If any check is returned for any reason, there is a $45 fee **IN ADDITION TO** the original amount of the check.

2. Your insurance policy is a contract between you and your insurance company. As a service to your, we will file your insurance claim if your assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we reserve the right to seek payment from you. We URGE you to be familiar with your coverage. Our office cannot be responsible for determining if your insurance covers laboratory work, diagnostic testing, annual visits, wellness visits or visits determined to be medically necessary.

3. We have arrangements with many insurance companies and other health plans to accept assignment of benefits. We will bill them, and you are required to pay a co-payment **AT THE TIME OF YOUR VISIT**. If the co-payment is not received, the office reserves the right to reschedule your appointment. If co-payment has not been received 30 days following the date of service, you will receive a bill with an **ADDITIONAL** $25 administration fee. A 2.5% per month service charge will be added to the bill beginning 30 days following the date of service.

4. If you are insured by a plan, that we do **NOT** have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. Theis means the insurer will send the payment directly to you. Therefore, our charges for you are **DUE AT THE TIME OF SERVICE**.

5. Not all insurance plans cover all services. Again, we **URGE** you to be familiar with your own insurance. In the event your insurance plan determines a service to "not be covered," you will be responsible for the complete charges. Payment is due upon receipt of a statement from our office. All non-covered charges are your responsibility from the date the services were rendered. You agree to pay any amount the insurance company will not pay.

6. Patients insured under the Medicare Program agree to allow Medicare to make payments directly to our office on your behalf. You agree to pay any balance due which Medicare does not pay, included but not limited to co-insurance, annual deductible and services not covered or rejected for any reason. I understand the total amount due is **MY** responsibility.

7. We reserve the right to charge for appointments not cancelled within 24 hours. These charges are **SOLELY YOUR** responsibility and **NOT COVERED** by **ANY** insurance.

8. We require a copy of a current credit card to be kept on file in the event your account balance remains outstanding after 60 days. We reserve the right to charge your credit card if you have not made any attempts to resolve the balance. This copy will secure with our billing department and not shared with anyone outside this office.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or responsible party, if a minor) Date

_____ _____

Print Name of the Responsible Party Print the name of the patient